

Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

The long shadow of cerebral localization

I am distinctly puzzled by Saad Shafqat's article on cerebral localization (December 2005 *JRSM*¹). The foundations of cerebral localization are generally accepted to have been laid by Paul Broca² and, more significantly, by Gustav Fritsch and Eduard Hitzig³ and David Ferrier.⁴

Dr Shafqat goes on to say 'The problem, unfortunately, is that lesion localization became an end in itself'. Oh? Within 5 years William Macewen was operating on abscesses of the brain that he had successfully located. He was soon followed by the likes of Victor Horsley, Charles Harrison Frazier and Harvey Cushing, all active before the end of the first decade of the 20th century. Besides abscesses, tumours and epilepsy were tackled by a handful of men with pretty satisfactory results considering the state of surgery at the time.⁵

Before computerized tomography and magnetic resonance scanning appeared on the scene, Walter Dandy had devised pneumoventriculography and Egas Moniz had introduced arterial encephalography.

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- 2 Broca P. Remarques sur le siege de la faculté du langage articulé, suivie d'une observation d'aphémie (perte de la parole). *Bull Soc Anatom Paris* 1861;**36**:330–57
- 3 Macewen W. Cases illustrative of cerebral surgery. *Lancet* 1885;i:934–6
- 4 Fritsch G, Hertzog E. Ueber die electrische Erregbarkeit des Grosshirns. *Arch Anat Physiol* 1870;**37**:300–32
- 5 Richardson R. *The Story of Surgery, with Commentaries*. Shrewsbury: Quiller Press, 2004 (see Chapters 14, 15 for references.)

Author's reply

By cerebral localization I am referring to the science of localizing normal and abnormal (lesional) function to discrete brain areas. Charcot had his share to say on this, as did others, and certainly Charcot's is the dominant voice in localization of abnormal cerebral function.^{1–3}

Dr Richardson has rightly stated the clear benefits of lesion localization (targeted neurosurgery for abscesses,

tumours and epileptic foci are fine representative examples); and I agree with the implication that lesion localization provided an impetus for the development of neurosurgery.⁴ My point, however, is that the hallowed status of this artful skill in the history of non-surgical neurology is undeserved. Prior to the modern era, the successful localization of a neurological lesion signalled the end of the clinical encounter in (non-surgical) neurological practice. A diagnostic exercise was thus transformed into 'an end in itself'.

It is the hold of lesion localization on the culture of neurology that made it a traditionally very diagnosis-centred specialty, when what really matters is to be treatment-centred. Only in the past 20 years, as clinical localization was rendered obsolete through modern imaging, have we started to come out of the shadows.

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Redisorganization theories

You are to be congratulated for publishing the paper by Oxman *et al.* (December 2005 *JRSM*¹). The authors are to be lauded for it. Underlying their presenting frivolity, they clearly express serious concerns.

It is surely redisorganizational practices which have done so much harm to the medical profession, and thereby to the patient. The first of these arose, of course, as the result of Bevan ignoring the conclusions of the Beveridge Report and the warnings of the Fellowship for Freedom in Medicine, instituting the NHS, rather than what was required—a national health insurance service. Doctor/patient confidentiality was destroyed on day 1, with clinical notes becoming the property of the Minister of Health.

Over the subsequent half century and more, further and further administrative intrusion into clinical matters has resulted in ever-increasing costs to the patient/tax-payer, concomitant with the medical profession being prevented from using more than half its time in the service of the patient. The patient must understand this.

What we need is not a 'peasants' revolt' but a 'patients' revolt'. We desperately need to mend the long-term damage done by generations of politicians/administrators.

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Challenges from the digital revolution

We note with interest the recent editorial (January 2006 *JRSM*¹) and letter (January 2006 *JRSM*²). They reflect facets of the massive growth in communications technology in healthcare. The doctor–patient relationship has been affected by the information available on the Internet and the presence of self-help groups and web sites moderated by expert patients.³ Geographical—but not linguistic—barriers are becoming irrelevant.

Another form of telephone consultation¹ of value is the nurse-lead telephone help lines run for patients with chronic conditions by centres of excellence—for instance, the Arthritis Centre, Northwick Park Hospital and the Scleroderma Centre at the Royal Free Hospital, London.

Outsourcing² is not restricted to moving tasks to lower cost centres: the opposite may occur. For example, on-line journal submission systems have moved tedious data entry away from journals' editorial staff to the submitting authors. Similarly, digital cameras, and easy-to-use software, have

allowed physicians to subsume the task of medical photography—albeit at lower quality than qualified medical photographers, who are also scrupulous in obtaining consent and meeting the needs of data protection. Regrettably, medical photography departments are being closed.

The availability of mobile phones with integral digital cameras allows physicians to capture ephemeral signs at the bedside or in the clinic. For instance, a camera phone was used by one of us to acquire an image of a transient rash that allowed the diagnosis of adult onset Still's disease to be reached.

But the use of mobile phones in hospitals remains contentious as they may affect medical equipment.⁴ Nevertheless, the widespread ownership and reliance on mobile phones makes blanket bans of their use in hospitals unenforceable.

We expect the use of telecommunications in healthcare to expand. It is clear, however, that innovation should be carefully risk assessed and monitored lest the law of unexpected (and unwanted) consequences be invoked.

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